

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | | (X3) DATE SURVEY COMPLETED 09/24/2014 |
| NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE & REHABILITATION CENTE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 SPRUCE LANE ELIZABETHTON, TN 37643 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| N 000 | Initial Comments A licensure survey was completed on September 24, 2014, at Pine Ridge Care and Rehabilitation Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Debbie Street

Administrator

10-10-14

STATE FORM

6899

2DH311

If continuation sheet 1 of 1

OCT 13 2014